NORTH CAROLINA	IN THE GENERAL COURT OF JUSTICE SUPERIOR COURT DIVISION
CARTERET COUNTY	13 CVS _____
DAVID B. HUGHES, SR. and KIMBERLY D. HUGHES, Administrators of the ESTATE OF ANDREW DAVIS HUGHES, DAVID B. HUGHES, SR., Individually and KIMBERLY D. HUGHES, Individually, Plaintiffs, vs. CARTERET COUNTY GENERAL HOSPITAL CORPORATION d/b/a CARTERET GENERAL HOSPITAL, Defendant.	**COMPLAINT AND DEMAND FOR JURY TRIAL**

Plaintiffs, complaining of defendant, allege and say:

1. Plaintiffs David B. Hughes, Sr. and Kimberly D. Hughes were appointed Administrators of the Estate of Andrew Davis Hughes, deceased, by the Clerk of Superior Court of Carteret County, in File Number 13 E 516, and are qualified and are now acting as Administrators in the institution of this action, pursuant to Chapter 28A of the General Statutes, and this action is instituted within two years from the death of plaintiffs' intestate, and is brought pursuant to the wrongful death statutes of North Carolina.

2. David B. Hughes, Sr. and Kimberly D. Hughes are the parents of Andrew Davis Hughes (hereinafter "Drew Hughes") and are citizens and residents of Carteret County, North Carolina.

3. Defendant Carteret County General Hospital Corporation d/b/a Carteret General Hospital (hereinafter "defendant Carteret General") was at all times relevant hereto, a corporation organized and existing under the laws of the State of North Carolina, with its principal place of business in Morehead City, North Carolina.

4. While decedent Drew Hughes was transported by Carteret General EMS, he was treated by paramedics, nurses, and respiratory therapists who were employees or agents of defendant Carteret General and undertook the care and treatment of him and were treating him within the course and scope of their employment and agency with defendant Carteret General at all times when they treated Drew Hughes.

5. Plaintiffs object to the pre-filing requirements of Rule 9(j) of the North Carolina Rules of Civil Procedure. Rule 9(j) effectively requires plaintiffs to prove their case before factual discovery is even begun, denies medical malpractice plaintiffs their rights of due process of law and equal protection under the law, the right to open courts, and the right to a jury trial, violates the separation of powers, and confers an exclusive advantage on health care providers, in violation of the United States and North Carolina constitutions. Rule 9(j) violates the Seventh and Fourteenth Amendments of the United States Constitution, and Article I, sections 6, 18, 19, 25 and 32 and Article IV, sections 1 and 13 of the North Carolina Constitution. Without waiving these objections, counsel for plaintiffs provided the following information to comply with the requirements of Rule 9(j): the medical care rendered by defendants and all medical records pertaining to the alleged negligence that are available to plaintiffs after reasonable inquiry have been reviewed before the filing of this complaint by persons who are reasonably expected to qualify as an expert witness under Rule 702 of the North Carolina Rules of Evidence and who are willing to testify that the care provided by defendants did not comply with the applicable standard of care. If the Court later determines that plaintiffs' 9(j) experts did not meet the requirements of Rule 702(b) or Rule 702(c), plaintiffs will seek to have that person qualified as an expert witness by motion under Rule 702(e) of the Rules of Evidence.

6. Plaintiffs object to N.C.G.S. § 90-21.19 ("the cap on noneconomic damages") as unconstitutional. The cap on noneconomic damages denies medical malpractice plaintiffs, including plaintiffs in this action, the right to a jury trial, due process of law, equal protection under the law, and the right to open courts, violates the separation of powers, and confers an exclusive emolument on health care providers, in violation of the United States and North Carolina constitutions. The cap on noneconomic damages violates the Seventh and Fourteenth Amendments of the United States Constitution and Article I, sections 6, 18, 19, 25 and 32 and Article IV, sections 1 and 13 of the North Carolina Constitution.

7. On June 28, 2013, Drew Hughes fell and hit his head while riding a skateboard. He was transported by ambulance to the emergency room of defendant Carteret General Hospital.

8. A CT of the head was normal but doctors suspected a possible basilar skull fracture, therefore, the decision was made to transport him to Vidant Medical Center in Greenville, NC. Because of weather conditions, he was transported by ground ambulance.

9. Drew was intubated and placed on an ambulance. The ambulance left Carteret General at approximately 11:10 p.m. with EMTs Laura Lewis and Sherrie Taylor, respiratory therapist Angela Kerntke and registered nurse Shannon Cox on board. Ms. Kerntke had been licensed for less than a year at this time and was not properly trained or adequately experienced in intubating a patient outside of a hospital setting.

10. The ambulance stopped outside of Newport, North Carolina to pick up paramedic Mike Murphy. Mr. Murphy took over as driver with Laura Lewis taking over patient care. Ms. Taylor departed the ambulance.

11. At approximately 11:15 p.m., shortly after the exchange of crew members, Drew awoke and pulled out his intubation tube. The crew had failed to recognize the signs Drew was waking up and had failed to properly sedate him. They also failed to properly restrain Drew, which would have kept him from pulling the ET tube out. Mike Murphy pulled the ambulance off the road and, according to the ambulance report, all four crew members worked to suction and re-intubate Drew with Angela Kerntke being primarily responsible for the attempted re-intubation. Drew was given paralytics and sedatives, which meant he could not breathe on his own. He was completely dependent on the oxygen from the endotracheal tube. Drew was intubated into his esophagus rather than his trachea and was not receiving oxygen and could no longer breathe on his own. At the time of the re-intubation, Drew's parents were parked in their car immediately behind the ambulance.

12. After the attempted re-intubation, the ambulance continued enroute to Vidant Medical Center. The crew never used objective testing, such as colormetric testing or capnography, to verify that the endotracheal tube was in his lungs and not his esophagus.

13. Almost as soon as the attempted re-intubation was done, Drew's heart rate began to drop and they could not find a pulse. According to the ambulance records, at approximately 11:25 p.m., Andrew's heart rate is in the 30s and he has no pulse. CPR was started and epinephrine was given.

14. According to the records a shock is given with a defibrillator at 11:38 p.m. CPR was continued. Drew's heart rate was in the 40s. More epinephrine was given. During this time, the emergency room physician at Carteret General was called to get permission to give Amiodarone. The emergency room physician told the crew to recheck

the tube and suction because the arrest may be respiratory related. The crew again failed to verify the tube placement.

15. The ambulance was diverted to Carolina East in New Bern because Drew's condition was deteriorating. They arrived at Carolina East at 11:43 p.m. according to the ambulance records. Drew had no pulse on arrival.

16. Once at Carolina East, the emergency room physician documented that Drew's color was cyanotic, there was no fogging of the ET tube and Drew had rumbling sounds in his stomach. All of these are classic signs of an esophageal intubation. A respiratory therapist at Carolina East immediately extubated and re-intubated Drew on the first attempt. Within a few minutes his blood oxygen saturation level returned to 100% and his vitals improved. However, blood gases were obtained which showed a ph. of 6.88, which is consistent with massive hypoxic brain damage from a lack of oxygen during the ambulance transport. Drew remained at Carolina East until approximately 1 a.m. at which time he was transferred by ambulance to Vidant Medical Center.

17. The ambulance crew failed to notify the doctors at Vidant of the esophageal intubation and the period of time that Drew was without oxygen.

18. Upon arrival at Vidant it was determined that Drew had no brain activity. Upon further testing it was determined that he met the criteria for brain death. Life support was withdrawn and Drew passed away.

19. In the medical treatment of Drew Hughes, employees and/or agents of defendant Carteret General Hospital were negligent in that:

a. They failed to keep Drew Hughes properly sedated and restrained;

b. They failed to properly re-intubate Andrew Davis Hughes during the transport;

c. They failed to perform standard objective tests to verify proper placement of the endotracheal tube;

d. They failed to recognize clear signs and symptoms of an esophageal intubation and respond to those signs;

e. They attempted to falsify the medical records to cover up their negligence;

f. They failed to use their best judgment in the treatment of Drew Hughes;

g. They failed to use reasonable care and diligence in the treatment of Drew Hughes and in the application of their knowledge and skill to the care of Drew Hughes;

h. They failed to possess the required skill and learning to treat Drew Hughes;

i. They failed to practice within the standard of care for respiratory therapists, nurses and/or paramedics in the same or similar communities; and

j. They were negligent in such other respects as may be shown at trial.

20. In addition, the actions of employees of defendant Carteret General and officers, directors and managers of Carteret General were grossly negligent and/or were done with reckless disregard for the rights and safety of others such that the cap on non-economic damages does not apply to this case.

21. The acts and omissions of employees and/or agents of defendant Carteret General, who were acting in the course and scope of their employment and agency at the time of the negligent acts, as alleged herein, are imputed to defendant Carteret General.

22. The aforesaid acts and conduct of the defendant was a proximate cause of the death of Andrew Davis Hughes.

23. As the result of the death of plaintiffs' intestate, the Estate of Andrew Davis Hughes has sustained and suffered great damages to which it is entitled to be compensated as set out in North Carolina General Statute Section 28A-18-2.

24. Plaintiffs David B. Hughes, Sr. and Kimberly D. Hughes have incurred medical expenses in an amount yet to be determined for medical care and attention for treatment of minor plaintiff Andrew Davis Hughes' injuries up to the time of his death.

25. As a direct, proximate and reasonably foreseeable result of the negligence of the defendants, plaintiffs David B. Hughes, Sr. and Kimberly D. Hughes sustained severe emotional distress and psychological injury. Defendants knew or should have foreseen that plaintiffs were likely to be highly susceptible to emotional injury and emotional distress as a result of defendant's negligence.

26. As a result of the negligence of defendant, plaintiffs David B. Hughes, Sr. and Kimberly D. Hughes are entitled to recover compensatory damages for medical expenses, and other expenses, incurred in the treatment of the minor plaintiff Andrew Davis Hughes up until the time of his death in an amount in excess of $10,000.00.

27. Plaintiffs are entitled to recover damages for infliction of severe emotional distress in an amount in excess of $10,000.00.

28. As a result of the negligence of defendants, plaintiffs are entitled, on behalf of the Estate of Andrew Davis Hughes, to recover damages in excess of $10,000.00.

WHEREFORE, plaintiffs pray the court:

1. That the Estate of Andrew Davis Hughes have and recover against the

defendant a sum in excess of $10,000.00 with interest thereon as by law provided as damages by reason of the wrongful death of Andrew Davis Hughes;

2. That plaintiffs David B. Hughes, Sr. and Kimberly D. Hughes have and recover from the defendant a sum in excess of $10,000.00 with interest thereon as by law provided as damages by reason of the medical expenses and other expenses incurred on behalf of plaintiff Andrew Davis Hughes.

3. That plaintiffs David B. Hughes, Sr. and Kimberly D. Hughes have and recover from the defendant a sum in excess of $10,000 with interest thereon as by law provided as damages as a result of their severe emotional distress.

4. That the cost of this action be taxed against the defendant.

5. That a jury trial be had on all issues so triable.

6. For such other and further relief as the court may deem just and proper.

This the _____ day of _____, 2013.

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